

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G412	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/10/2012
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for the fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 8/1/12, 8/2/12 and 8/10/12</p> <p>Facility number: 000926 Provider number: 15G412 AIMS number: 100244470</p> <p>Surveyor: Keith Briner, Medical Surveyor III/QMRP</p> <p>This deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed August 20, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 clients with adaptive equipment (#3), the facility failed to ensure client #3 had a pair of prescription eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/1/12 from 4:48 PM through 6:22 PM and on 8/2/12 from 6:15 AM through 7:45 AM. Client #3 was observed in the group home throughout the observation periods. Client #3 did not wear eyeglasses during the observation periods.</p> <p>Client #3's record was reviewed on 8/2/12 at 9:04 AM. Client #3's Vision Examination form dated 5/2/11 indicated client #3 had a prescription for eyeglasses. Client #3's record indicated she had been discharged from the facility on 11/14/11 and readmitted on 5/25/12.</p> <p>Interview with AS (Administrative Staff) #1, MC #1 (Medical Coordinator) and</p>	W0436	<p>The prescription eyeglasses have been obtained for client #3. A goal has been put into place to encourage the routine wearing of the eyeglasses for client #3 as well. See attachment. The program nurse will routinely review medical orders to ensure that ordered adaptive equipment is secured. The residential director will ensure that if necessary goals will be developed for the use and care of the adaptive equipment.</p>	08/31/2012

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	<p>QMRP (Qualified Mental Retardation Professional) #1 on 8/3/12 at 3:15 PM indicated client #3 did not return to the group home on 5/25/12 with her prescription eyeglasses. MC #1 indicated the facility had not made arrangements with the optometrist to ensure client #3 had prescription eyeglasses.</p> <p>9-3-7(a)</p>			